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ABSTRACT

This report to the U.S. Senate Committee on Finance evaluates Medicaid reimbursements to schools for health services provided to children. The report addresses: (1) the extent to which school districts and states claim Medicaid reimbursement for school-based health services and administrative activities; (2) the appropriateness of methods states use to establish "bundled rates" for school-based health services and the costs of administrative activities that schools may claim as reimbursable; (3) states' retention of federal Medicaid reimbursement for services provided by schools' practice of paying contingency fees to private firms; and (4) the adequacy of the Health Care Financing Administration's (HCFA) oversight of state practices regarding school-based claims, including safeguards to ensure appropriate billing for health services and administrative activities. Conclusions included that three states (Illinois, Michigan, and New York) accounted for over 60 percent of all health services payments; that payments ranged from a high of $820 per eligible child (in Maryland) to less than 5 cents per child (in Mississippi); that bundled rate methods often fail to account for variations in service needs or document actual services provided; and that HCFA has provided weak direction and program oversight. Appendices include an HCFA letter to state medical directors and comments from HCFA on this report. (DB)

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GAO

Report to the Chairman and Ranking Minority Member, Committee on Finance, U.S. Senate

ED 443 251

April 2000

MEDICAID IN SCHOOLS

Improper Payments Demand Improvements in HCFA Oversight

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Abbreviations

EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
HCFA	Health Care Financing Administration
IDEA	Individuals With Disabilities Education Act
OMB	Office of Management and Budget
OSI	Office of Special Investigations
SPMP	skilled professional medical provider

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United States General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-283378

April 5, 2000

The Honorable William V. Roth, Jr.
Chairman
The Honorable Daniel Patrick Moynihan
Ranking Minority Member
Committee on Finance
United States Senate

Schools can be appropriate locations in which to identify low-income children who are eligible for Medicaid, assist them to enroll, and provide them Medicaid-covered services. Under Medicaid, a joint federal-state program that spent about $177 billion in fiscal year 1998, the federal government pays a share of costs incurred by the states in providing health care to 41 million low-income beneficiaries, including 13 million school-aged children. States may use their Medicaid programs to pay for certain health services provided to eligible children by schools, including diagnostic screening and ongoing treatment, such as physical therapy. States may also obtain reimbursement from the federal government for the costs of administrative activities associated with providing Medicaid services in schools, such as conducting outreach activities to assist with enrolling children in Medicaid; providing eligibility determination assistance, program information, and referrals; and coordinating and monitoring Medicaid-covered health services.

In June 1999, we testified before your Committee about multimillion-dollar increases in Medicaid reimbursements for administrative activities in schools in 10 states and the need for more federal and state oversight of these growing expenditures.[1] In particular, we found that weak and inconsistent controls over the review and approval of claims for school-based administrative activities created an environment in which inappropriate claims could generate excessive Medicaid reimbursements. We also found that some school districts receive only $4 of every $10 that the federal government pays to reimburse them for Medicaid-allowable administrative costs, after the state takes a share of the federal payment and private firms are paid. Private firms are often engaged by school

[1]See *Medicaid: Questionable Practices Boost Federal Payments for School-Based Services* (GAO/T-HEHS-99-148, June 17, 1999).

districts to design the methods used to claim Medicaid reimbursement, train school personnel to apply these methods, and submit the claims to state Medicaid agencies to obtain federal reimbursement.

Since our initial review was limited to administrative cost claims, you requested that we expand our analysis of state practices regarding Medicaid reimbursement of school-based administrative activities and address as well the use of "bundled" rates for school-based services. Bundled rates are single payments for a package of various services that eligible special education children may need over a specified period of time; a fixed amount is paid per child on the basis of the services the child is expected to require, not on the basis of the services the child actually receives. This report addresses (1) the extent to which school districts and states claim Medicaid reimbursement for school-based health services and administrative activities; (2) the appropriateness of methods states use to establish bundled rates for school-based health services and to assess the costs of administrative activities that their schools may claim as reimbursable; (3) states' retention of federal Medicaid reimbursement for services provided by schools and schools' practice of paying contingency fees to private firms; and (4) the adequacy of the Health Care Financing Administration's (HCFA) oversight of state practices regarding school-based claims, including safeguards employed to ensure appropriate billing for health services and administrative activities.

To examine these issues, we surveyed the 50 states and the District of Columbia, focusing on their Medicaid policies and practices related to school-based health services and administrative activities. We visited six states in various regions of the country—Florida, Illinois, Massachusetts, Michigan, New Jersey, and Vermont—that allow schools to bill Medicaid for providing health services and carrying out administrative activities and that represent a mixture of methodologies for submitting claims for administrative activities, transportation to and from services, and bundled rate payments.[2] We also interviewed officials in 7 of HCFA's 10 regional offices, the 17 states that allow claims for Medicaid-related administrative activities, and the 8 states and the District of Columbia that HCFA identified as using bundled rate payments for health services. In addition, our Office of Special Investigations (OSI) began ongoing investigative work

[2]States can cover transportation services either as administrative activities or as direct health services; thus, our selection of states covered both these methods of submitting Medicaid claims.

in July 1999 to determine whether fraudulent or abusive practices are occurring. OSI conducts its investigations in accordance with the standards of the President's Council on Integrity and Efficiency. We performed our work between July 1999 and March 2000 in accordance with generally accepted government auditing standards.

Results in Brief

Nearly all states reported Medicaid expenditures for school-based activities, which totaled $2.3 billion for the latest year of available state data.[3] The majority of payments—about $1.6 billion—were for health services provided by schools in 45 states and the District of Columbia, and about $712 million was for administrative activities billed by schools in 17 states. Three states—Illinois, Michigan, and New York—accounted for over 60 percent of total school-based claims. New York accounted for 44 percent of all health services payments, while Illinois and Michigan together accounted for 74 percent of all administrative activity payments. Medicaid payments to schools ranged from a high of nearly $820 per Medicaid-eligible child in Maryland to less than 5 cents per child in Mississippi, reflecting in part variation in the proportion of states' school districts that submitted claims for Medicaid services and activities.

Some of the methods used by school districts and states to claim reimbursement for school-based services do not ensure that health services are provided, or that administrative activities are properly identified and reimbursed. Bundled rate methods used by school districts to claim Medicaid reimbursement for school-based health services have failed in some cases to take into account variations in service needs among children and have often lacked assurances that services paid for were provided. In two states, monthly payments ranging from $141 to $636 per child were made to schools solely on the basis of at least 1 day's attendance in school, rather than on documentation of any actual service delivery. With regard to administrative activities, poor controls have resulted in improper payments in at least two states, and there are indications that improprieties could be occurring in several other states. Examples follow.

[3]States were asked to provide school-based claims data for the most recent fiscal year for which they were available, which for approximately half the states was state fiscal year 1999. Most of the remaining states provided data for state fiscal year 1998, federal fiscal year 1998, or calendar year 1998; three states provided data for periods before July 1997.

- The HCFA Chicago regional office questioned $30 million in administrative claims submitted by the state of Michigan for the quarter ending September 1998 for school activities that were not related to Medicaid. Among other issues, school staff interviewed by HCFA revealed that activities they performed that were related to general health screenings, family communications, or staff-related training had no Medicaid component or benefit, although a portion of their staff time was claimed and reimbursed as such. The HCFA regional office deferred Michigan's claim for $33 million in federal payment for the quarter ending September 1999, asking again that the state better document that school-based claims for administrative activities were clearly linked to Medicaid.
- Our investigation and HCFA scrutiny of claims have also found that Michigan and Illinois claimed reimbursement for services such as health evaluations performed for the benefit of non-Medicaid-eligible children. The resulting improper payments for non-Medicaid-eligible children accounted for $12.5 million of the $56 million in federal reimbursement that was reviewed in Michigan for the quarter ending September 1998 and $7.7 million in Illinois for the quarter ending March 1999. Our investigation in Michigan identified approximately $28 million in improper federal reimbursement for 2 years.

In some states, funding arrangements among schools, states, and private firms can create adverse incentives for program oversight and cause schools to receive a small portion—as little as $7.50 for every $100 in Medicaid claims—of Medicaid reimbursement for school-based claims. We found that 18 states retained a total of $324 million, or 34 percent, of federal funds intended to reimburse schools for their Medicaid-related costs; for 7 of these states, this amounted to 50 to 85 percent of federal Medicaid reimbursement for school-based claims. In addition, contingency fees, which some school districts pay to private firms for their assistance in preparing and submitting Medicaid claims, ranged from 3 to 25 percent of the federal Medicaid reimbursement, further reducing the net amount that schools receive. While school districts can—and do—pay private firms for assistance with Medicaid claims, these fees are not allowable for federal reimbursement. Yet, our investigation determined that in one state a school district inappropriately included contingency fees on a Medicaid administrative cost claim.

Finally, HCFA's overall weak direction and oversight have contributed to the problems we identified. Although at least one HCFA regional office has identified cases of improper payments, to date no consistent attempt has

been made to determine how pervasive these practices may be in other regions and states or to halt them as quickly as possible. Moreover, problems we identified in last June's testimony—ambiguous policies and inconsistent oversight—continue and, in fact, have been exacerbated. For example, HCFA's attempt to clarify transportation policies for school-based services has been interpreted differently among regional offices, resulting in inequitable treatment of school district claims for special transportation needs. Recognizing that schools can be effective sites in which to identify low-income children eligible for Medicaid, assist them to enroll, and provide them Medicaid services, we are making recommendations to the Administrator of HCFA that are aimed at improving the development and consistent application of clear policies and appropriate oversight for school-based Medicaid services. Additionally, we are referring evidence of certain improprieties and other matters to the cognizant U.S. Attorney's Offices for appropriate action.

Background

Medicaid is a joint federal-state program that in fiscal year 1998 spent about $177 billion to finance health coverage for 41 million low-income individuals, 13 million of whom are school-aged children. States operate their programs within broad federal requirements and can elect to cover a range of optional populations and benefits. As a result, Medicaid essentially operates as 56 separate programs: 1 in each of the 50 states, the District of Columbia, Puerto Rico, and the U.S. territories. Medicaid is an entitlement program under which the states and the federal government are obligated to pay for all covered services provided to an eligible individual.

Medicaid costs shared by the federal government and the states fall under one of the following two categories: medical assistance (called "health services" in this report) and administrative activities. Each state program's federal and state funding shares of health services payments are determined through a statutory matching formula. This formula results in federal shares that range from 50 to 83 percent, depending on a state's per capita income in relationship to the national average. For administrative activities claims, the federal share varies by the type of costs incurred. Most administrative expenditures are shared equally between the federal government and the individual state. However, certain administrative expenditures are eligible for higher federal matching funds.[4] Over 95 percent of Medicaid's $177 billion in total expenditures in fiscal year 1998 was spent on health services.

Medicaid, IDEA, and School-Based Health Services

Schools can help identify eligible low-income children, assist them to enroll, and provide them Medicaid-covered services, and states are authorized to use their Medicaid programs to help pay for certain health care services delivered to these children in schools. In addition, Medicaid is authorized to cover health services provided to children under the Individuals With Disabilities Education Act (IDEA).[5]

Children who qualify for IDEA have access to a wide array of services, and Medicaid may cover the costs of health-related services provided to eligible children. In particular, IDEA obligates schools to provide the "related services" that are required to help a child with a disability benefit from special education, including transportation, speech-language pathology, and physical and occupational therapy. Because many services required by the individualized plan developed to address the specific needs of a child with a disability are health-related, Medicaid is an attractive option for funding many IDEA services. Children who qualify for IDEA are frequently eligible for Medicaid services, and although Medicaid is generally the payer of last resort for health care services, it is required to pay for IDEA-related

[4]For example, federal matching funds pay 90 percent of costs for the development of automated information systems and 75 percent of costs for some activities performed by skilled professional medical personnel.

[5]IDEA, 20 U.S.C. 1400, covers public school children with disabilities and emphasizes special education; it also covers such related services as transportation, speech language pathology and audiology, psychological services, physical and occupational therapy, and counseling.

medically necessary services for Medicaid-eligible children before IDEA funds are used.

IDEA requires that states have in effect policies and procedures to ensure the identification, location, and evaluation of all children with disabilities who are in need of special education and related services, a concept termed "child find." Some activities under Medicaid, such as outreach in support of Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, can be coordinated with IDEA activities.[6] While related, these two programs still have distinguishing goals: IDEA's child-find activities are focused on identifying and meeting the educational needs of children with disabilities, while EPSDT outreach is directed at informing children who are potentially eligible for Medicaid about benefits available under the EPSDT program and facilitating the Medicaid application process.

Medicaid Claims for School-Based Health Services

Commonly provided school-based health services that qualify for Medicaid reimbursement include physical, occupational, and speech therapy as well as diagnostic, preventive, and rehabilitative services. Schools that submit claims to their state Medicaid agency for reimbursement for health services must meet Medicaid provider qualifications established by their state and must have a provider agreement with the state Medicaid agency.[7]

In addition, states must develop a methodology for determining payment rates for school-based health services. Payment rates are established by the state Medicaid agency, described in a state plan, and approved by HCFA. Although states have broad discretion in establishing payment rates, they must be reasonable and sufficient to ensure the provision of quality services and access to care. Within these general payment principles, however, considerable variation can exist. For example, states may set a

[6]EPSDT is a benefit that provides certain comprehensive treatment and preventive health care services for Medicaid-eligible children under age 21 if these services are medically necessary, regardless of whether they are covered under a state's Medicaid plan. Under the EPSDT benefit, states are required to conduct activities to inform individuals about EPSDT and to encourage their participation in the Medicaid program.

[7]Schools providing Medicaid services employ a variety of service delivery models, including directly employing health providers, making contractual arrangements with providers for specific services, operating fully equipped and staffed school health clinics, or some combination thereof.

payment rate for each individual service provided or base Medicaid reimbursement on the actual costs providers incur in supplying services.

Until recently, states have been allowed to develop methods to bundle payments for a specified group of services. However, in a May 21, 1999, letter to state Medicaid directors, HCFA prohibited states' use of this approach because HCFA had concluded that bundled rate methodologies do not produce sufficient documentation of accurate and reasonable payments. HCFA informed states that it would not be considering further proposals by states to use a bundled rate payment system. HCFA directed states with bundled rates to develop and prospectively implement an alternate reimbursement methodology. HCFA expected states to come into compliance with its May 21, 1999, letter within a reasonable time frame and stated it would consider taking action if this did not occur. While HCFA expects to issue further clarification on bundled rates some time this year, states with previously approved bundled rates continue to use them.

Medicaid Claims for School-Based Administrative Activities

Schools may also receive reimbursement for the costs of performing administrative activities related to Medicaid. Administrative activities performed by school districts and schools may include Medicaid outreach, application assistance, and coordination and monitoring of health services. Unlike the requirements for health services claims, a school does not need to become a qualified Medicaid provider to submit administrative activity claims. However, there must be (1) either an interagency agreement or a contract that defines the relationship between the state Medicaid agency and other parties and (2) an acceptable reimbursement methodology for calculating payments for administrative activities.

Cost allocation plans are expected to be supported by a system that has the capability to properly identify and isolate the costs that are directly related to the support of the Medicaid program. States must also abide by the cost allocation principles described in Office of Management and Budget (OMB) Circular A-87, which requires, among other things, that costs be "necessary and reasonable" and "allocable" to the Medicaid program.[8]

[8]Other relevant provisions of the Medicaid statute and regulations include sec. 1903(a) of the Social Security Act and implementing regulations at 42 C.F.R. 430.1 and 42 C.F.R. 431.15. In order for the costs of any administrative activities to be allowable and reimbursable under Medicaid, the activities must be "found necessary by the Secretary for the proper and efficient administration of the plan."

HCFA Guidance on Medicaid Reimbursement for School-Based Health Services

In August 1997, HCFA issued a technical assistance guide for Medicaid claims for school-based services.[9] This guide provides general information and guidelines regarding the specific Medicaid requirements associated with federal reimbursement for the costs of school health services and administrative activities. HCFA requires states to provide and maintain appropriate documentation and assurances that claims for administrative activities do not duplicate other claims or payments.

HCFA's May 21, 1999, letter to state Medicaid directors, in addition to prohibiting bundling payments, attempted to clarify HCFA's policy on transportation and stated that HCFA was in the process of updating its guiding principles related to claims for school-based administrative activities costs. (See app. I for the full text of the May 21, 1999, letter.) In February 2000, HCFA released for public comment a draft of its revised technical assistance guide on submitting school-based administrative activity claims.[10]

Medicaid School-Based Activities Involve a Variety of State Practices; Expenditures Continue to Grow

While nearly all the states had Medicaid expenditures for school-based activities, the extent of participation varied widely, with the volume of Medicaid administrative expenditures having grown significantly in recent years. Total Medicaid claims for the most recent year of available state data range from $8,000 in Mississippi to $682 million in New York; average claims per Medicaid-eligible child range from less than 5 cents in Mississippi to nearly $820 in Maryland. This variation can be partially explained by the proportion of school districts within a state that choose to file claims. Recent payments for school-based administrative activities reflect the growing number of school districts making claims for Medicaid reimbursement for these activities. Moreover, in addition to the 17 states that currently allow their schools to bill Medicaid for school-based administrative activities, 12 states have indicated that they may do so in the future. As a percentage of total Medicaid administrative expenses, payments for school-based administrative activities range from less than 1 percent in 1 of the 17 states allowing such claims to over 45 percent in Michigan and Illinois.

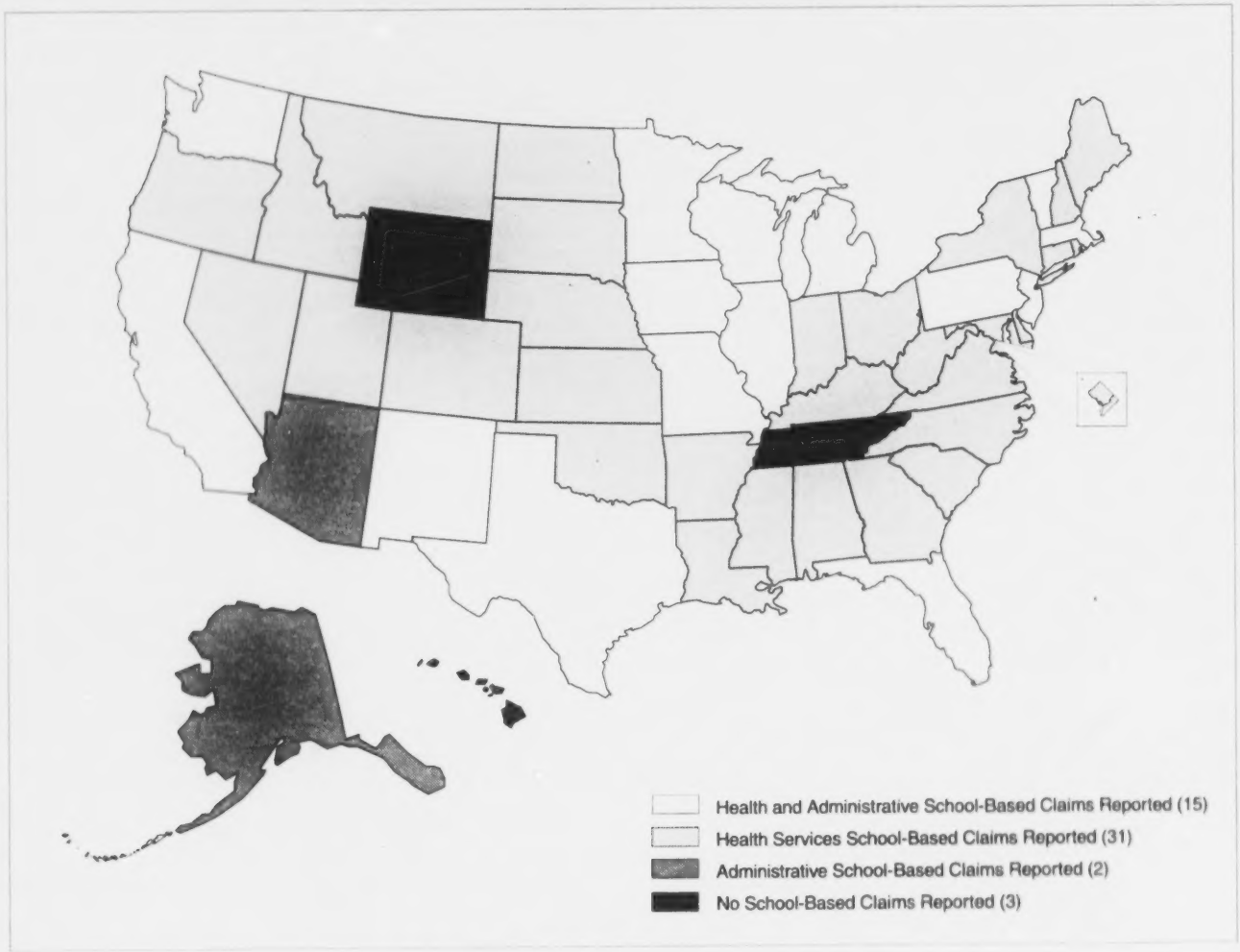
[9]See HCFA, Center for Medicaid and State Operations, *Medicaid and School Health: A Technical Assistance Guide* (Washington, D.C.: HCFA, Aug. 1997).

[10]HCFA's draft guidance can be located on the Internet at http://www.hcfa.gov/medicaid/schools/machmpg.htm.

The Extent of School-Based Claims Varies

While nearly all states allow schools to submit claims to their state Medicaid agencies for school-based health services, administrative activities, or both, the extent to which school districts choose to do so varies. Our survey of the 50 states and the District of Columbia found that schools in 47 states and the District of Columbia obtain Medicaid payment for school-based health services, administrative activities, or both. While 15 states allow claims for both health services and administrative activities, 30 states and the District of Columbia allow Medicaid payment for health services only. Two states—Alaska and Arizona—limit their school-based Medicaid payments to administrative activities, and schools in three states—Hawaii, Tennessee, and Wyoming—do not claim Medicaid reimbursement for either type of school-based service. (See fig. 1.)

Figure 1: States Reporting Medicaid Claims for School-Based Services, December 1999


Health and Administrative School-Based Claims Reported (15)
Health Services School-Based Claims Reported (31)
Administrative School-Based Claims Reported (2)
No School-Based Claims Reported (3)

Source: GAO survey of states.

States also vary substantially in the amount of their Medicaid payments for school-based activities. Medicaid payments to schools ranged from less than 5 cents per Medicaid-eligible child in Mississippi to nearly $820 per child in Maryland. Three states—Illinois, Michigan, and New York—accounted for over 60 percent of total school-based claims. New York

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rcent of all health services payments, while Illinois and nted for 74 percent of all administrative activity payments. nong the 45 states and the District of Columbia that provide ursement for school-based health services, such claims ed for periods ranging from 2 to 28 years. For the 17 states dicaid reimbursement for school-based administrative claims have been allowed for between 1 and 8 years.

Table 1: States' Annual School-Based Claims, Ranked by Average Claim per Medicaid-Eligible Child Aged 6 to 20

State	Average claim per Medicaid-eligible child	School-based claims (in thousands)		
		Total claims	Health claims	Administrative claims
Maryland	$818	$93,824	$93,824	[a]
New York	703	682,000	682,000	[a]
Illinois	674	385,633	82,946	$302,687
Michigan	674	317,701	93,534	224,167
New Hampshire	658	24,894	24,894	[a]
Rhode Island	600	27,482	27,482	[a]
Delaware	394	13,900	13,900	[a]
Maine	350	22,000	22,000	[a]
Vermont	309	12,798	11,041	1,757
Kansas	291	25,741	25,741	[a]
Massachusetts[b]	284	65,250	45,750	19,500
Alaska	265	7,780	[a]	7,780
District of Columbi	265	12,100	12,100	[a]
Wisconsin[c]	249	45,904	44,312	1,591
New Jersey	248	66,328	60,671	5,657
Connecticut	174	22,216	22,216	[a]
Pennsylvania	121	68,507	54,555	13,952
Arizona	115	25,795	[a]	25,795
Utah	114	7,279	7,279	[a]
Minnesota	105	23,766	271	23,495
Texas	88	78,030	66,368	11,662
Washington	87	30,367	11,973	18,394
Oregon	85	12,441	12,441	[a]

Continued

State	Average claim per Medicaid-eligible child	School-based claims (in thousands)		
		Total claims	Health claims	Administrative claims
South Carolina	79	14,247	14,247	[a]
New Mexico	72	10,348	5,439	4,909
Ohio	66	31,953	31,953	[a]
Florida	59	41,518	3,067	38,451
Nebraska	58	3,916	3,916	[a]
Missouri	55	15,381	4,277	11,104
Iowa	52	5,255	4,171	1,084
Nevada	48	1,900	1,900	[a]
Arkansas	45	5,428	5,428	[a]
Colorado[d]	44	4,885	4,885	[a]
North Dakota	41	826	826	[a]
South Dakota	31	906	906	[a]
Montana	29	892	892	[a]
Louisiana	26	6,269	6,269	[a]
West Virginia	24	3,044	3,044	[a]
Georgia	21	9,167	9,167	[a]
Idaho[d]	20	781	781	[a]
California	19	42,308	42,020	288
Oklahoma	10	1,311	1,311	[a]
Kentucky	6	1,228	1,228	[a]
Virginia	5	1,201	1,201	[a]
North Carolina	2	722	722	[a]
Alabama	1	132	132	[a]
Indiana	[a]	60	60	[a]
Mississippi	[a]	8	8	[a]
Hawaii	[a]	[a]	[a]	[a]
Tennessee	[a]	[a]	[a]	[a]
Wyoming	[a]	[a]	[a]	[a]
Total		**$2,275,423**	**$1,563,150**	**$712,273**

Continued from Previous Page

Note: States provided school-based claims data for the most recent fiscal year for which they were available, which for approximately half the states was state fiscal year 1999. Most of the remaining states provided data for state fiscal year 1998, federal fiscal year 1998, or calendar year 1998; three states provided data for periods before July 1997. The average claim per Medicaid-eligible child was calculated by dividing the total school-based claims by the number of school-aged Medicaid-eligible children.

[a]This state did not report school-based claims in this category.

[b]Massachusetts provided 6 months of administrative claims data, which we extrapolated to reflect a full year of claims.

[c]Wisconsin's school-based health claims and administrative claims do not equal its total school-based claims because of rounding.

[d]Colorado and Idaho provided 11 months of health services claims data, which we extrapolated to reflect a full year of claims.

[e]The average claim per Medicaid-eligible child was less than $1.

Source: GAO analysis of state-reported claims data and HCFA's fiscal year 1997 eligibility data (2082 report).

Some of the variation in Medicaid payments for school-based services and cost per Medicaid-eligible child is explained by differences in the proportion of school districts submitting Medicaid claims for school-based activities. For some states, schools are part of the state Medicaid health services delivery system, while in other states, schools may not generally provide direct health services. For example, two states that spent relatively little per Medicaid-eligible child—Indiana, at less than $1 per child, and Alabama, at $1 per child—both indicated low percentages of school district participation, with an Indiana official estimating approximately 3-percent participation. A state official in California, which spent less per Medicaid-eligible child than 40 other states, estimated that in state fiscal year 1998 about 75 percent of the school districts in the state submitted claims for health services, while only 2 school districts submitted claims for administrative activities.

States also varied in whether they considered certain activities to be health services or administrative activities, which could have affected federal reimbursement because the federal match rate for health services is higher than the rate for administrative activities in many states. According to HCFA's technical assistance guide, Medicaid currently allows states to reimburse transportation and case management as health services, administrative activities, or both. For example, schools in Maryland and Nevada claim school-based transportation as a health service, while those in Massachusetts classify transportation as an administrative activity. Similarly, Illinois schools claim case management as an administrative activity, while those in New York claim it as a health service.[11] A Michigan official reported that schools submit claims for case management as a health service once the individualized plan for a child with a disability has

[11]In New York, schools actually claim targeted case management, which differs from case management in that states are allowed to waive certain Medicaid requirements. In other words, the state may target individuals by different criteria, such as age, degree of disability, illness, or condition.

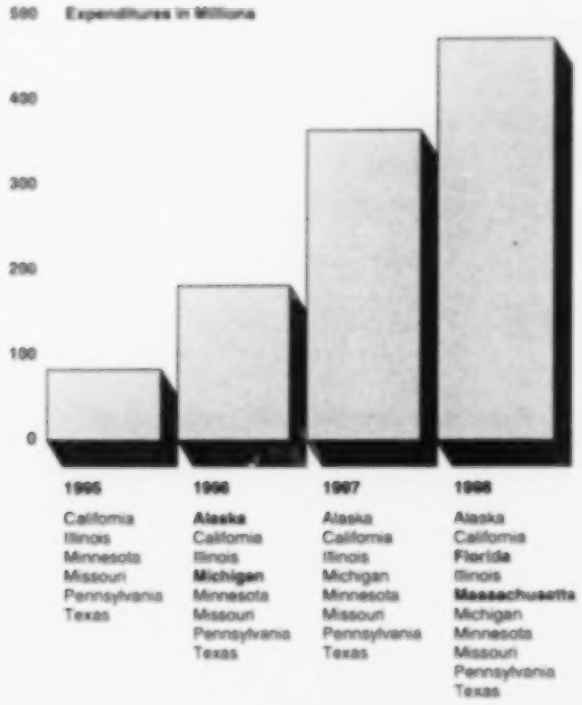
been developed and written, while case management that takes place before such a plan is developed is claimed as an administrative activity.

An Increasing Number of States Pay—or Are Considering Payment—for School-Based Administrative Activities

In June 1999, we testified that a growing number of states pay for reimbursement of school-based administrative activities, and our recent survey suggests that this growth will continue. From fiscal year 1995 through fiscal year 1998, Medicaid claims for administrative activities increased fivefold, from $82 million to $469 million (see fig. 2).[12] These increased Medicaid expenditures for school-based administrative activities reflect growth in the number of states participating, the number of schools participating, and the size of claims submitted by individual school districts. For example, from 1996 to 1997, Michigan's Medicaid administrative claims for schools increased almost threefold, from $79 million to $227 million, which state and school officials indicated was primarily the result of an increase in the number of school districts submitting claims.

[12]Ten of the 17 states that allow reimbursement for school-based administrative services were readily able to provide trend data: Alaska, California, Florida, Illinois, Massachusetts, Michigan, Minnesota, Missouri, Pennsylvania, and Texas.

Figure 2: Medicaid School-Based Administrative Claims for 10 States, Fiscal Years 1995-98



Note: States that appear in bold lettering began claiming school-based administrative expenditures in the year listed.

Source: State-reported claims.

Interest in submitting claims to Medicaid for administrative activities performed in the schools was evident in our recent survey of the 50 states and the District of Columbia. In addition to the 17 states that currently allow Medicaid reimbursement for school-based administrative activities, officials in 12 other states reported that they are considering allowing school-based claims for these activities in the future. Seven other states reported that they were "not sure" if they would allow schools to submit Medicaid claims for administrative activities.[13] (See table 2.) Of those states considering Medicaid reimbursement for school-based administrative costs, eight identified some possible activities for which they would pay, including eligibility facilitation, outreach, transportation, program planning and monitoring, case management, referral, and coordination.

Table 2: Positions on Reimbursement for Medicaid School-Based Administrative Activities of Those States That Do Not Currently Pay Claims

Considering reimbursement	Uncertain	Not considering reimbursement
Alabama	District of Columbia	Colorado
Arkansas	Hawaii	Connecticut
Georgia	Indiana	Delaware
Idaho	Maryland	Kentucky
Kansas	Mississippi	Louisiana
Nebraska	Montana	Maine
Nevada	Virginia	New Hampshire
North Carolina	(7)	New York
Ohio		North Dakota
Oklahoma		Rhode Island
Oregon		South Carolina
Utah		South Dakota
(12)		Tennessee
		West Virginia
		Wyoming
		(15)

Source: GAO survey of states.

[13]As part of our survey on school-based services, states were asked whether they were considering submitting Medicaid claims for school-based administrative activities. States had the option of selecting "yes," "not sure," or "no."

School-Based Administrative Claims Represent a Significant Share of a Few States' Total Medicaid Administrative Costs

The school-based administrative claims of a few states constitute a significant share of their total Medicaid administrative activity. For example, these claims represented 47 percent and 46 percent, respectively, of Michigan's and Illinois' total Medicaid administrative claims. Other states—Alaska, Arizona, and Washington—had school-based claims as high as 19 to 20 percent of their total Medicaid administrative expenditures. (See table 3.) A significant portion of the growth in the administrative costs of four states resulted from reimbursing for school-based activities: Alaska, Illinois, Michigan, and Minnesota all showed average annual growth rates for school-based administrative expenditures that were at least twice as high as the growth rate of all their other Medicaid administrative expenditures combined.[14]

Table 3: States' Medicaid School-Based Administrative Claims as a Percentage of Total Medicaid Administrative Expenditures

State	School-based Medicaid administrative claims (in thousands)	Total Medicaid administrative expenditures (in thousands)[a]	Percentage of total administrative expenditures
Michigan	$224,167	$477,138	47
Illinois	302,687	661,188	46
Arizona	25,795	131,577	20
Washington[b]	18,394	91,745	20
Alaska	7,780	40,662	19
New Mexico	4,909	32,078	15
Florida	38,451	289,625	13
Minnesota	23,495	209,412	11
Massachusetts[c]	19,500	190,669	10

Continued

[14]Of the 17 states that claim Medicaid reimbursement for school-based administrative costs, we examined administrative expenditures for the 8 states that could readily provide data for multiple years and compared the growth rates for school-based administrative expenditures against all of the 8 states' other Medicaid administrative expenditures. The eight states were Alaska, California, Illinois, Michigan, Minnesota, Missouri, Pennsylvania, and Texas. In Michigan and Minnesota, the base year for this calculation is the year the states began claiming school-based administrative activities and may not represent a full year of claims activity.

State	School-based Medicaid administrative claims (in thousands)	Total Medicaid administrative expenditures (in thousands)[a]	Percentage of total administrative expenditures
Missouri	11,104	131,024	8
Vermont	1,757	35,659	5
Pennsylvania	13,952	387,262	4
New Jersey	5,657	253,991	2
Texas	11,662	576,952	2
Iowa	1,084	70,125	2
Wisconsin	1,591	138,555	1
California	288	1,227,657	Less than .02

Continued from Previous Page

Note: States were asked to provide administrative claims data for school-based services from the most recent fiscal year. Although most states provided data from the year ending June 30, 1999, two states provided data from calendar year 1998, two states provided federal fiscal year 1999 data, and three states provided data from state fiscal year 1999 (July 1, 1997–June 30, 1998).

[a]States provided total Medicaid administrative expenditures for the same period as for the school-based administrative claims data.

[b]Although Washington provided school-based administrative claims data for the year ending August 31, 1999, total Medicaid administrative expenditures were provided for the closest year of data available, federal fiscal year 1999 (October 1, 1998–September 30, 1999).

[c]Massachusetts provided 6 months of school-based administrative claims data, which we extrapolated to reflect a full year of claims.

Source: State-reported claims data.

Methods Used to Claim Medicaid Do Not Ensure That Services Are Provided or Administrative Activities Are Properly Identified and Reimbursed

Some methods used to claim Medicaid reimbursement do not adequately ensure that health services are provided or that administrative activities are properly identified and reimbursed. Paying bundled rates for health services can simplify requirements for schools that participate in the Medicaid program; however, bundled rates can also create an incentive to stint on services, or to change what services children receive or where they receive them to increase payment. To counteract these incentives, bundled rate methods should differentiate payments among children with varying levels of need and provide assurances that necessary services are provided. However, not all states using a bundled payment approach differentiate levels of need among children or ensure that services paid for are provided. In addition, poor controls over what constitutes an allowable administrative activity cost claim have resulted in improper Medicaid reimbursements. In some cases, Medicaid claims were inappropriately reimbursed because they represented administrative activities that were not Medicaid-related. In other cases, claims for administrative activities

performed by skilled medical professionals, which can be eligible for reimbursement at a higher matching rate of 75 percent, were submitted and paid without adequate documentation to justify the higher rate.

Bundled Rates Simplified Claims and Were Expected to Limit Adverse Incentives

HCFA began to allow states to develop bundled payment approaches in an attempt to simplify schools' reporting requirements under Medicaid. We reviewed the payment approaches of seven states that currently use bundled rates.[15] Bundled payments are somewhat comparable to capitation payments made to managed care organizations. A school district receives a single payment for all the covered services a child needs during a specified period, such as a day or month.[16] Bundled payments have the advantage of simplifying schools' submission of claims. One state official told us that the less complicated paperwork involved with bundled rates has made it easier for smaller schools to submit claims for Medicaid reimbursement.[17]

Bundled rates can also reduce the negative incentives that may exist under other payment approaches. For example, reimbursing schools on the basis of their actual costs may undermine interest in delivering services efficiently. In addition, a fee-for-service approach, which is used by the majority of states, does not provide schools with an incentive to control the volume of services provided because schools in these states receive more revenue for providing more services. (See table 4.) Counteracting the adverse incentives that may exist under these other payment approaches is challenging. Reviewing utilization or cost reports to establish that costs are allowable or services are necessary is expensive. In contrast, bundled rates can help limit the costs of delivering services by creating the incentive to provide needed services more efficiently. Under a bundled approach,

[15]These states are Connecticut, Kansas, Maine, Massachusetts, New Jersey, Utah, and Vermont. Although HCFA identified the District of Columbia and North Carolina as having bundled rates, we did not include them in our analysis. We eliminated the District of Columbia from our discussion because it applies a bundled rate to only two schools; all other schools submit claims on a fee-for-service basis. We excluded North Carolina because all of its schools currently submit claims on a fee-for-service basis, although a number of schools had previously used a bundled approach.

[16]Services included in the bundled rates are relatively similar among the seven states and typically include audiology; counseling; and physical, speech, and occupational therapy. One notable exception is transportation, the cost of which only four of the seven states include in their bundled rates.

[17]See *Medicaid and Special Education: Coordination of Services for Children With Disabilities Is Evolving* (GAO/HEHS-00-20, Dec. 10, 1999).

however, costs can also be limited by neglecting to provide all needed services or by compromising the quality of individual services provided. These undesirable effects can be reduced by modifying how bundled rates are paid and exercising additional oversight of the services delivered.

Table 4: Incentives Affecting Volume and Cost of Services, by Payment Approach

	Do incentives exist for providers to increase	
Payment approach	Volume of services to an individual?	Unit cost?
Cost-based reimbursement	Yes	Yes
Fee-for-service rates	Yes	No[a]
Bundling rates	No[b]	No[a]

[a]Under this payment approach, incentives to increase the unit cost do not exist, provided the unit costs are based on reasonable and appropriate costs.

[b]Bundled rate payments can, however, provide an incentive to inappropriately decrease the volume of services provided.

Source: GAO analysis of payment incentives.

Some States' Bundled Payment Methods Lack Sufficient Accountability

In order for bundled rate methods to result in appropriate payments, the amount paid should be appropriately aligned with the expected cost of services. For schools, bundled payments that take into account the variation in service needs among children and ensure that services are provided help ensure that Medicaid funds are appropriately spent and children's needs met. However, the methods currently employed by some of the seven states using bundled rates do not satisfy these criteria (see table 5).

Table 5: Approaches to School-Based Payments in Seven States Using Bundled Rates

State	Does the bundled rate vary depending on the needs of the child?[a]	What is the unit of payment for services?[a]	What event triggers submitting a claim to Medicaid for reimbursement?
Connecticut	No—one statewide rate	Monthly rate—$336 per child	Receipt of one service
Kansas	Yes—14 statewide rates; vary by primary disability	Monthly rate—$151–$636 per child	School attendance 1 day a month
Maine	Yes—13 statewide rates; vary by primary disability	Monthly rate—$141–$442 per child	School attendance 1 day a month
Massachusetts	Yes—seven statewide rates; vary by time spent in a regular classroom	Six daily rates—$11–$48 per child; one weekly rate—$106 per child	School attendance
New Jersey	Yes—four statewide rates; vary by type of school	Daily rate—$33–$172 per child	Receipt of one service
Utah	No—school-specific rates	Daily rate—$21–$60 per child	School attendance
Vermont	Yes—four statewide rates; vary by number of services actually provided	Monthly rate—$162–$1,598 per child	Receipt of a specified number of services

[a]States may exclude certain services, such as development and evaluation of the individualized plan of a child with a disability, EPSDT diagnosis and treatment, and provision of medical equipment, from their bundled rates and separately claim Medicaid reimbursement for these services.

[b]For all but one state, the rates are current and are rounded to the nearest dollar. The rates listed for Vermont are from the 1998-99 school year. Vermont's rates have historically been adjusted annually for salary increases.

Source: State Medicaid agencies.

As table 5 indicates, states' bundled rates vary in the extent to which they adjust payments among children with different medical needs. For example, the bundled rates of two states—Connecticut and Utah—do not recognize that the costs for providing services to children with different medical needs may vary considerably. Participating schools in Connecticut receive a monthly payment of about $336 for each eligible child, regardless of whether that child has a mild learning disability or has multiple physical and cognitive disabilities. This statewide rate may not cover the full costs incurred by schools that have a disproportionate number of children whose services cost more, which may affect schools' ability to provide necessary services. Conversely, other schools may be paid an amount higher than their actual costs. In two other states, Massachusetts and New Jersey, the payment level is based on the location of the child, and not necessarily on the number or scope of services that he or she receives. Specifically, Massachusetts' schools are paid on the basis of the percentage of time an

eligible child spends in a regular classroom, whereas New Jersey has four statewide rates that vary depending on where the child attends school.[18]

Bundled payment rates in other states, such as Kansas, Maine, and Vermont, are more aligned with the expected cost of services for specified groups of children. For example, schools in Kansas and Maine receive the same payment amount for all children with specified disabilities, such as autism or mental retardation. While these rates do not recognize differences in the number and intensity of services provided to children within each disability category, they do recognize that schools can incur significantly higher costs for children with certain disabilities. Vermont does not distinguish among types of disabilities but does have four different levels of reimbursement, which vary depending on the number of services a child actually receives in a given week, as well as on who provides those services.[19]

In addition, states' bundled approaches should ensure that services paid for are actually provided. However, payments currently made in four of the seven states—Kansas, Massachusetts, Maine, and Utah—are not specifically linked to the receipt of services because reimbursement is triggered simply by school attendance. Participating schools in these states are reimbursed the bundled rate for each eligible child, irrespective of whether the child has received any services. For example, schools in Kansas are reimbursed about $476 a month for each child whose primary disability listed on the individualized plan is autism, as long as the child attended school at least 1 day in a given month. In such an arrangement, there is little accountability for providing needed services because attendance—not the receipt of services—triggers reimbursement.

Varying levels of assurances exist in Connecticut, New Jersey, and Vermont that services are actually provided to eligible children. For example, schools in Connecticut must document on a monthly service information form the number and type of services provided to each child. However,

[18]New Jersey pays schools according to four categories: in-district school, out-of-district school, nonpublic school, and state facility.

[19]Thus, schools are reimbursed a lower amount for children in level one, who receive fewer than 6 units of service a week, than for those in level three, who receive from 12 to 24 units of service a week. Vermont's approach also recognizes differences in the costs of services provided by aides and professionals. For example, 1 hour of individual therapy provided by a certified physical therapist is equal to three units of service, while an hour of therapy provided by an aide equals one unit.

schools have to provide a child with only one service during the month to be eligible for the full payment. Similarly, New Jersey schools can claim the per diem reimbursement for each day an eligible child receives at least one service that is documented by the school. In Vermont, case managers complete for each child a level-of-care form that categorizes the hours of service, type of provider, and setting (one-on-one or group). Using these data, a clerk computes the total units of service each child receives to justify the payment for one of four levels of care.

Poor Controls Have Resulted in Improper Reimbursement for Administrative Claims

Poor controls on the part of states and school districts have resulted in improper reimbursements for Medicaid administrative claims. The methods states allow school districts to use to determine administrative costs strongly influence the amount of Medicaid reimbursement school districts receive. Determining allowable Medicaid-related administrative costs involves identifying direct costs, such as for personnel and supplies, and allocating them between Medicaid and non-Medicaid activities, as well as allocating an appropriate share of indirect (overhead) costs to Medicaid.[20] In most cases, school personnel involved in special education can serve both Medicaid and educational functions; thus, the costs of administrative activities must be allocated to each function.[21] Two aspects of the methods for determining administrative cost allocations are vulnerable to contributing to overstated Medicaid costs: (1) time study methodologies, which are used to identify the portion of staff time spent on Medicaid-related activities, and (2) activity codes, which are used to identify functions performed by school staff in these time studies. In addition, some school districts have received reimbursement for administrative activities at the enhanced 75-percent federal matching rate for skilled professional medical providers, such as physical therapists, without providing adequate documentation that their professional capabilities were needed for such activities, as required by Medicaid regulations.

[20]Of the 17 states that reimburse for administrative costs in schools, school districts in 4—Alaska, California, Vermont, and Wisconsin—do not include indirect costs in their claims.

[21]In a few instances, school personnel may be completely allocated to Medicaid administrative activities. For example, schools may employ "Medicaid clerks," whose primary function is to provide the administrative support necessary for schools to submit Medicaid claims to the state.

Different Time Study Methods Have Led to Considerable Variation in Reimbursement

Some time study methods that states allow schools and school districts to use in determining Medicaid-related school-based administrative costs are questionable and could be used to inappropriately increase Medicaid payments. Differences in time study methodologies can—and do—affect the level of states' reimbursements. States vary in the extent to which they instruct school districts on the type of time study methodology permitted.

We identified three basic methods used to allocate the time of school personnel to Medicaid-related administrative activities: the representative period, random moment, and continuous log methods.[22] The representative period method is the one most vulnerable to manipulation. In contrast to the random moment time study, for example, which always randomly selects a period of time to be studied, representative periods may not always be randomly selected. This method is also the one most frequently used. Of the 17 states with schools that file administrative cost claims, 15 allow the use of representative period time studies for determining cost allocations.[23] Moreover, 9 of the 15 states that specify the use of a representative period study either specify the use of a nonrandom representative period or allow the school districts or private firms involved in the time studies to make this decision.[24]

How the selection of the sample period can affect study results is illustrated by an example from Florida. When a private firm representing nine Florida school districts changed the time study method they used from a sampling period of 1 week per quarter to a random sample of moments throughout the quarter, the amount of federal reimbursement claimed decreased by 50 percent.

[22]For representative period time studies, participants record all their activities in 15-minute increments for a given period of time, typically 1 week. For random moment time studies, participants record their activities for randomly selected moments in a specified period of time, such as a federal fiscal quarter. In contrast, the continuous log approach requires specified service providers to track how their time is spent on an ongoing basis.

[23]Five states—Florida, Illinois, Iowa, Missouri, and Washington—allow more than one type of time study methodology.

[24]The remaining six states that use a representative period time study specify that the time period must be randomly selected. Minnesota and Vermont, the two states that do not allow representative period time studies, use random moment and continuous log studies, respectively.

Loosely Defined Activity Code Categories Have Overstated Costs Related to Medicaid

Loosely defined activity code categories used by time study participants to record time spent on administrative activities have resulted in overstated Medicaid costs.[25] While typical activity code categories may include outreach related to the Medicaid program, coordinating and monitoring of health services, and facilitating Medicaid eligibility determinations, these categories and their codes vary among and within states, particularly when multiple private firms contract with school districts within a state to submit administrative cost claims.

While staff from HCFA's central office and several regional offices emphasized the importance of developing clearly defined activity codes, some states' methods allow certain activities to be inappropriately claimed as Medicaid administrative costs. For example, HCFA's Chicago regional office questioned activities for which $30 million in federal reimbursement had been claimed and paid for one quarter for participating schools in Michigan. The activity codes in question included general health screenings, communication with families, and staff training as Medicaid administrative activities. However, HCFA regional office interviews with a sample of staff who allocated their time to these activity codes revealed no direct connection between staff activities and Medicaid; these staff did not know what Medicaid covers, where or how to apply for Medicaid, or who might qualify for coverage. Moreover, the only Medicaid-related training activity identified in HCFA's review was for purposes of completing the time study; interviewed school staff indicated that Medicaid was not mentioned during other identified training sessions. The activity codes in question constituted 53 percent of the $56 million in federal reimbursement claimed for administrative activities by Michigan's school districts for the quarter ending September 1998. HCFA recommended that Michigan revise its time study's activity code definitions to more accurately identify activities related to the Medicaid program or recipients. The HCFA regional office deferred Michigan's claim for $33 million in federal reimbursements for the quarter ending September 1999, asking again that the state better document that school-based claims for administrative activities were clearly linked to Medicaid.

[25]School personnel completing an administrative claim time study allocate their time to different categories, or activity codes, depending on the activities performed in a given period of time. Activity codes are generally not limited to Medicaid-reimbursable activities and may include codes for educational activities and general administration.

Our investigation and HCFA scrutiny of claims in Michigan and Illinois also disclosed federal reimbursements for health reviews and evaluations performed for the benefit of non-Medicaid-eligible children. These improper claims for non-Medicaid-eligible children in schools accounted for $12.5 million of the $56 million in federal reimbursement that was reviewed in Michigan for the quarter ending September 1998 and a $7.7 million reimbursement to Illinois—$2.4 million for one school district consortium for the quarter ending December 1998 and $5.3 million for the quarter ending March 1999 for the remaining school districts that claim reimbursement. Our investigation in Michigan identified approximately $28 million in improper federal reimbursement for 2 years.

Our review of the 17 states that allow schools to file administrative claims showed that some of the questionable activity code definitions used in Illinois and Michigan are also being used for activity codes in 9 other states. Of these nine states, four do not specifically mention Medicaid in descriptions of relevant activities.[26] In contrast, at least one state preferred to develop its own activity codes, rather than adopt those already in use in other states, because the other state codes were "too loose to be appropriate" and did not differentiate Medicaid-related activities from those relating to non-Medicaid-eligible children.

Claims Based on Professional Credentials Have Resulted in Questionable Payments

Claims for administrative activities performed by skilled professional medical providers (SPMP) at the 75-percent enhanced matching rate have also resulted in questionable payments. Of the 17 states submitting claims for administrative costs, 11 states allow the use of the SPMP enhanced rate for school-based administrative claims. In general, the SPMP rate can be legitimately used only when the person (1) has the appropriate credential, such as a nurse, occupational therapist, or physical therapist, and (2) performs an administrative activity that requires professional medical knowledge and skills. For example, a nurse who meets with a child and notices a condition that needs medical attention could submit a claim for this activity at the SPMP enhanced matching rate of 75 percent. However, a nurse who only arranges a medical appointment for a child would not need

[26]For example, Medicaid-related activities might be one component of a code that is widely used in education, such as staff training. Under these circumstances, non-Medicaid activities could constitute a disproportionate share of the total costs in one activity code, even if the code was subsequently allocated between Medicaid and non-Medicaid costs. A more appropriate approach for assigning costs would be to establish two activity codes for training—one that identified all Medicaid-related training and one that identified all other training.

his or her credentials to make an appointment and thus would not be eligible for the 75-percent enhanced matching rate. The enhanced matching rate of 75 percent for SPMP administrative activities can be a strong incentive for those preparing and submitting claims, as it increases by 50 percent the amount of federal reimbursement that can be received.

In two states—Illinois and Michigan—we found that, on the advice of private firms, school districts have submitted claims that inadequately document the need for professional credentials for purposes of submitting an SPMP claim. For example, we found that one private firm told the SPMPs in its client school districts to claim the enhanced rate for every administrative activity they perform, rather than document in each case whether their skill was required. Another private firm told SPMPs that, when tracking their time, they had only to check a box to indicate that their medical credential was necessary for a particular activity, and that no further documentation or proof was needed for the enhanced Medicaid reimbursement.[27] Recent SPMP claims in Illinois totaled $16.6 million, or 37 percent of its total claims, for one quarter for participating school districts.[28] In Michigan, SPMP claims totaled $14 million, or 25 percent of the state's total administrative activity for all participating school districts for the quarter ending September 1998.[29]

[27]HCFA regulations state that federal reimbursement rates in excess of 50 percent should apply only to those portions of the individual's work time that are spent carrying out duties in the specified areas for which the higher rate is authorized. The regulations further state that the allocation of personnel and staff costs must be based on either the actual percentages of time spent carrying out duties in the specified areas or another methodology approved by HCFA. See 42 C.F.R. 432.50(c)(2), (3).

[28]The time period of the claims for one group of school districts was the quarter ending December 1998, and the time period for the remaining school districts' claims was the quarter ending March 1999.

[29]In these two states, overall SPMP claims for administrative expenditures have increased four- and fivefold since the states began paying for school-based administrative costs. With the exception of Iowa, whose claims for SPMP activities increased twelvefold from 1994 to 1998, other states that submitted administrative claims prior to 1998 had much lower increases. We excluded California from our analysis because it reported significantly less than $1 million in school-based administrative claims ($288,000).

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States' Retention of Federal Reimbursement—and Contingency Fees Paid to Private Firms—Reduce the Federal Dollars Schools Receive

Funding arrangements among states, schools, and private firms create adverse incentives for program oversight and significantly reduce the amount of federal dollars that schools receive for Medicaid-related services and activities. Of the 47 states and the District of Columbia that submit claims on behalf of schools for health services, administrative activities, or both, 18 retain some portion of federal Medicaid reimbursements rather than fully reimbursing schools for their Medicaid-related costs. Because states can benefit directly in this way from higher federal payments, states' incentives to exercise strong oversight over the propriety of school-based claims can be diminished. In addition, many school districts have contingency arrangements with private firms that pay them a share of Medicaid reimbursement, in some cases, a percentage of the federal share of reimbursement received from a claim. Embedded in both of these practices are incentives for states and private firms to experiment with "creative" billing practices, some of which we have found to be improper. Moreover, the result of these actions is that, in some states, schools could receive as little as $7.50 in federal Medicaid reimbursements for every $100 spent to pay for services and activities performed in support of Medicaid-eligible children.

States' Ability to Retain Federal Medicaid Funds May Weaken Oversight

Eighteen states retain a portion of the federal Medicaid reimbursement resulting from school districts' claims. According to several state officials, because state budgets fund a portion of school activities, Medicaid services provided by schools are partially funded by the state. According to this reasoning, some states believe they should receive a share of the federal reimbursements claimed by school districts. However, it is not clear that state, rather than local, funds support the Medicaid-reimbursable services, as opposed to other educational activities for which states provide funds. Moreover, we believe that such a practice severs the direct link between Medicaid payment and the services delivered and increases the potential for the diversion of Medicaid funds to purposes other than those intended.

We found that seven states retain from 50 percent to 85 percent of the federal Medicaid reimbursement for health services, while another nine states retain between 1 and 40 percent of federal payments. Among the states that claim Medicaid reimbursement for administrative activities, three retain 50 percent or more of the federal reimbursement, while another seven keep between 1 and 40 percent. (See table 6.)

Table 6: Amount and Percentage of Federal Medicaid Reimbursement for Health Services and Administrative Activities Retained by States

State	Percentage of federal reimbursement for health services retained	Percentage of federal reimbursement for administrative activities retained	Amount retained by state (in thousands)[a]
New Jersey	85	85	$25,815
Iowa	75	0	1,984
Delaware	70	[b]	4,865
Vermont	60	15	4,266
Alaska	[b]	52	2,023
New York	50	[b]	170,500
Pennsylvania	50	50	18,079
Washington[c]	50	0	3,122
Connecticut	40	[b]	4,443
Michigan	40	40	69,156
Wisconsin	40	40	10,749
Illinois[d]	10	10	6,391
New Mexico	5	5	314
Ohio	4	[b]	741
Utah	2	[b]	105
Colorado	2	[b]	50
Massachusetts	1	1	326
Minnesota	0	5	587
Total			**$323,516**

[a]States provided school-based claims data for the most recent fiscal year for which they were available, which for approximately half the states was state fiscal year 1999. Most of the remaining states provided data for state fiscal year 1998, federal fiscal year 1998, or calendar year 1998; three states provided data from before July 1, 1997.

[b]This state does not claim reimbursement for this type of school-based activity.

[c]Washington retains at least 50 percent of federally reimbursed funds but can retain a higher percentage depending on whether the school district is "fully participating" in billing Medicaid for school-based services.

[d]When total Medicaid payments to an Illinois school district exceed $1 million in a year, 10 percent of the portion exceeding $1 million is retained for the state's general revenue fund. According to the state, 22 of its 900 school districts received more than $1 million.

Source: State-reported data.

When a state benefits directly from federal reimbursements for schools, questions arise concerning its incentives to exercise appropriate oversight

of Medicaid program operations for school-based claims. The improper activities cited in this report—particularly those for administrative cost claims—are symptomatic of the lack of sufficient oversight, such as state-level reviews of school-based claims for their appropriateness. For example, one auditor from the Department of Health and Human Services' Office of Inspector General told us that Medicaid program oversight in one state is geared toward ensuring adequate documentation of claims and not toward examining claims for appropriateness. Our contacts with the auditors' offices of six states revealed that these states conducted no state-level reviews of Medicaid school-based claims.

Moreover, we identified similar concerns about states' oversight in our investigation of improper practices in making school-based fee-for-service claims for health services. For example, our investigation of fee-for-service payments for health services in one state revealed that schools were submitting, and the state was paying, transportation claims for all Medicaid children who had received a Medicaid health service at school without verifying that the child had used school bus transportation. Our investigation further identified instances in which the transportation services for which the state submitted claims were not provided, resulting in improper Medicaid reimbursements. In another investigation, we uncovered practices under which Medicaid was inappropriately billed for health services in one state, and other investigators identified similar practices in another state. Specifically, in both states, some group therapy sessions were billed as individual therapy sessions, which resulted in a higher payment for the school.

Contingency Fees Paid to Private Firms May Encourage Questionable Claims

Some school districts paid private firms fees ranging from 3 percent to 25 percent of the federal reimbursement amount claimed; fees most commonly ranged from 9 to 12 percent. These firms are usually hired to assist with administrative cost claims, generally designing the methods used to make these claims, training school personnel to apply these methods, and submitting administrative claims to state Medicaid agencies to obtain the federal reimbursement that provides the basis for their fees.[30] By receiving a percentage of reimbursement rather than a fixed fee, these

[30]Of the six states we visited, only Vermont did not reimburse a private firm on a contingency basis. Instead, to develop its bundled approach, Vermont used a firm that had been under contract with the state for several years and was paid on a fixed-fee basis.

firms have an incentive to maximize the amount of reimbursements claimed.

Private sector interest in working with states and school districts to seek Medicaid reimbursement for administrative activities is high. In addition to the 17 states that currently submit administrative claims, officials from at least 7 other states told us that private firms interested in developing administrative claims methodologies had recently contacted them or schools in their state.

Marketing materials from two private firms explain one of the reasons concerns have been expressed that school districts' administrative claims may exceed reasonable or allowable costs. In these materials, the firms assert that their objectives are to maximize Medicaid revenues for schools and that they can maximize a school's claim potential by training school personnel to follow their methods for claiming costs. One firm emphasized that, on average, its clients annually receive over 30 percent more per student than schools contracting with a competitor.

While schools can—and do—pay private firms on a contingency basis for Medicaid-related services, these contingency fees do not qualify for federal Medicaid reimbursement.[31] OMB Circular A-87, which establishes the principles and standards for determining "reasonable" and "allocable" costs for federal programs such as Medicaid, states that the costs of professional and consultant services rendered are allowable when reasonable and when not contingent upon the recovery of costs from the federal government.[32] In one state, our investigation determined that contingency fees were improperly included in one school district's Medicaid administrative cost claim. We estimate that the resulting unallowable costs claimed for reimbursement may approximate $1 million for a 5-year period.

[31]See 45 C.F.R. secs. 74.1(3), 74.27, 92.22.

[32]See attachment B to OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments* (Washington, D.C.: OMB, revised 5/2/95, as further amended 8/29/97).

In Some States, Schools Receive a Small Portion of Medicaid Reimbursement

In some states, schools can receive a small portion of Medicaid reimbursement for performing covered health services and administrative activities on behalf of eligible children. In addition to states' policies to retain a portion of federal Medicaid reimbursement and school districts' contractual arrangements to pay private firms a share of their federal reimbursements, the school districts' budgets often serve as the local funds that are used to supply the state's share of Medicaid funding for school-based claims. When school funds provide the state share of Medicaid reimbursement, the maximum additional funding that a school district can receive for delivering services or performing administrative activities is what the federal government contributes. This is substantially less than what a private sector Medicaid provider would receive for delivering and submitting a claim for similar services.[33] For example, a physician who submits a claim with an allowable amount of $100 will receive $100: $50 in state funds and $50 in federal funds.[34] In contrast, when a school district submits a claim for $100, and the school district pays the state's share of this claim, the maximum the school district can receive is the $50 federal share. Of the 47 states that allow Medicaid claims for school-based activities, 38 use local funds for the state match to federal dollars.[35] Table 7 shows the variation in the amounts different schools might receive in Medicaid reimbursement for the claims they submit, given the source of the states' share of funding, states' policies to retain portions of the federal reimbursement, and contingency fee arrangements with private firms.

[33]Local funding as the source of a state's share of Medicaid reimbursement is not unique to schools; it is most likely to exist when there are multiple governmental entities involved in the delivery of Medicaid health services or administrative activities. For example, local funds are being used as a source of the state share of the cost of publicly funded hospitals and mental health services.

[34]This example assumes a 50 percent matching rate and that the claim submitted is a legitimate statement of health services or administrative activities performed in support of the Medicaid program.

[35]Because the District of Columbia does not distinguish between state and local funds, we excluded it from this analysis.

Table 7: Variations in Schools' Receipt of Medicaid Reimbursement for Health Services

	State					
	Florida	Illinois	Vermont	Michigan	New Jersey	Minnesota
Amount claimed	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00
Local funds used[a]	(44.18)	(50.00)	(38.03)	(47.28)	(50.00)	0
Amount retained by state[b]	0	(5.00)[c]	(37.18)[d]	(21.09)	(42.50)	0
Total Medicaid funds received by school district	55.82	45.00	24.79	31.63	7.50	100.00
Amount paid to private firm by school district[e]	(10.05)[f]	(8.25)	0	(10.54)	[g]	[h]
Net amount to school district	$45.77	$36.75	$24.79	$21.09	$7.50	$100.00

[a]This amount reflects the state's share of Medicaid funding for health services for fiscal year 1999. For administrative activities, states' shares would generally be 50 percent.

[b]The amount retained by the state is deducted from the federal reimbursement.

[c]When total Medicaid payments to an Illinois school district exceed $1 million in a year, 10 percent of the portion exceeding $1 million is retained for the state's general revenue fund. According to the state, 22 of its 900 school districts received more than $1 million.

[d]The percentage retained by Vermont varies from year to year. The amount noted reflects the percentage retained for Vermont's 1999 school year.

[e]Private firms' contingency fees vary across school districts and states; thus, the dollars reported in this table are estimates of typical contingency fees paid by school districts.

[f]Effective February 14, 2000, contingency fee reimbursement contracts are prohibited for school districts in Florida.

[g]The state of New Jersey pays the firm $2.55 from the $42.50 it retains.

[h]Minnesota state officials were not aware of any contingency fee arrangements being used by school districts; thus, we did not report dollars in this example.

Source: GAO analysis of state data.

HCFA Oversight Does Not Ensure the Appropriateness of School-Based Claims

HCFA oversight practices—past and present—have not ensured the appropriateness of school-based practices for claiming Medicaid reimbursement. As we testified in June 1999, HCFA's guidance in the past has generally left much to regional office discretion, resulting in inconsistencies in the oversight and review of claims. Written guidance has consisted primarily of a technical assistance guide and a direction for states to follow the federal requirements for administrative cost allocations found in OMB Circular A-87. Despite HCFA's May 21, 1999, letter, which was partially intended to provide clarification in areas concerning bundling and submitting claims for administrative activities and special transportation services, HCFA regional offices continue to interpret policies inconsistently.[36] This lack of adequate direction and oversight has permitted the development of an environment of opportunism and has led to improper Medicaid claims for administrative activities and limited assurances that children are receiving appropriate services.

Without Additional Direction From HCFA, Alternatives to Bundled Rate Methods Have Not Been Developed

In its May 21, 1999, letter, HCFA instructed states with bundled rates to develop and implement an alternative reimbursement methodology but did not provide a time frame in which to do so.[37] To assist states in this effort, the agency also announced that it would create a work group of officials from states using bundled approaches, the Department of Education, and other federal agencies to discuss alternative arrangements.

However, since HCFA issued this letter, the seven states that were using a bundled approach continue to do so. In fact, officials in some of these states told us that they intend to continue to use their bundled approaches

[36]See app. I for the full text of the HCFA letter issued on May 21, 1999. The letter addressed three areas. First, HCFA directed that bundled rates for school-based health services that were previously evaluated and approved by HCFA would no longer be acceptable for purposes of submitting a Medicaid claim. Second, HCFA stated that it was conducting a review of practices to develop administrative cost claims and that it expected to publish a guide in the summer of 1999 to clarify the requirements for submitting claims for Medicaid administrative activities in schools. Finally, HCFA informed states that children with special education needs who ride the regular school bus to school with children without disabilities should not have transportation listed as part of their individualized plan and that the cost of that bus ride should not be billed to Medicaid.

[37]HCFA raised concerns that bundled rates could not be connected to a specific type of procedure and were not available to other community providers. Also, the agency said that schools did not maintain sufficient documentation to establish the reasonableness of the bundled rates, and, thus, Medicaid could be overpaying for certain services.

until HCFA clarifies its position or issues additional guidance. Furthermore, the work group that was established as a result of the HCFA letter is currently inactive. While the group initially met weekly via telephone, its members neither made any formal decisions about the future of bundling nor developed alternative payment approaches. In October 1999, HCFA officials announced that the group would not reconvene until sometime in 2000, because it needed time to discuss issues concerning bundling. As of March 1, 2000, the work group had not yet reconvened.

Inconsistencies in HCFA Oversight of Administrative Claims Continue

HCFA has made some efforts to improve oversight of school-based administrative claims. It has conducted individual reviews of practices identified in this report in a few states and is working with a few states to revise their activity codes to more accurately capture the costs associated with Medicaid-related activities in schools. Finally, the additional guidance that HCFA testified in June 1999 would be forthcoming was released for public comment in February 2000.

Despite these efforts, the lack of clear guidance on how to develop methods for submitting administrative claims continues to result in significant inconsistencies among regions. For example, while some HCFA regional offices have scrutinized the details of states' methodologies for developing administrative claims, other regional offices have had little or no involvement in the development of their states' methodologies. The area of enhanced rates for skilled providers is a specific example of the contradictory policies of regional offices. The Chicago regional office allows Illinois and Michigan school districts to claim administrative activities provided by SPMPs at a 75-percent match rate as opposed to the general administrative match rate of 50 percent. In contrast, the school districts in Massachusetts are not allowed to claim this enhanced rate because HCFA's Boston regional office does not allow the higher rate. According to officials in the Boston office, "there was no way in the world" to document that certain activities required a skilled level of performance. Still other HCFA regional offices, such as San Francisco, have adopted a different approach, allowing the use of the enhanced rate under certain circumstances.

HCFA's Attempt to Clarify Its Special Transportation Policy Raises More Questions Than It Answers

HCFA's attempt to clarify its policy on school districts' practices in claiming Medicaid reimbursement for special transportation related to school-based services has added to the uncertainty surrounding this issue rather than clarifying the matter. The HCFA letter indicated that school districts should not bill to Medicaid the transportation costs of a child who qualifies for special education under IDEA and who rides the regular school bus with children without disabilities. According to HCFA central office officials, the general intention was to discontinue the practice of allowing Medicaid reimbursement for children who needed no additional assistance and could ride the regular school bus by themselves without any special equipment or the assistance of an aide.

However, regional offices and states have conflicting interpretations of what an appropriate special transportation claim is, with the likely result that Medicaid reimbursement will continue to be inconsistent across states.

- Officials in one of the seven regional offices that we spoke with correctly believed that Medicaid would cover transportation costs if a child was able to ride on a regular school bus but required the assistance of an aide; two other regional offices incorrectly asserted that transportation costs could not be reimbursed because the child would not be riding a specially adapted vehicle; and officials in the remaining four regional offices did not know whether reimbursement would be allowed.
- Officials in two of the states we visited told us they will now allow school districts to claim Medicaid reimbursement only for the use of vehicles that have a wheelchair lift or some adaptation that would meet the needs of children with physical disabilities—a policy that is inconsistent with the intent that HCFA officials described to us.
- At least two states are awaiting further clarification from HCFA and continue to have school districts that claim transportation costs for children with special education needs who receive a Medicaid service at school—including costs for those riding regular school buses with an aide.

The inconsistent interpretations cited above raise concerns of unequal consideration of children with different types of disabilities. In particular, state and school districts are unclear regarding HCFA's policy for submitting claims for children who have behavioral needs or developmental disabilities, but no physical disability. In many cases, these children have the physical capability to ride the regular school bus but may need the assistance of an aide to ride the bus because of cognitive impairments or behavioral concerns. Further, some contend that requiring a physically adapted bus in order to receive reimbursement—as is currently interpreted by some states and HCFA regional offices—may conflict with the concept of "least restrictive environment"; thus, children may be unnecessarily segregated into specialized transportation.[38]

Conclusions

Almost one-third of Medicaid-eligible individuals are school-aged children, which makes schools an important service delivery and outreach point for Medicaid. Even when schools do not directly provide Medicaid-covered health services, schools can undertake administrative activities that help identify, refer, screen, and assist in the enrollment of Medicaid-eligible children. Outreach and identification activities help ensure that the most vulnerable children receive routine preventive health care and ongoing primary care and treatment. Most states are seeking Medicaid funds to assist them in providing medically related services to children with disabilities and to link children to appropriate health services.

Given the broad range of school and state practices, to date there have been poor controls on the varied approaches to submitting claims for Medicaid reimbursement for school-based health services and administrative activities. Such controls must achieve an appropriate balance between the states' needs for flexible, administratively simple systems and the assurance that federal funds are being used for their intended purposes. HCFA's current oversight practices have failed to provide that assurance, resulting in confusing and inconsistent guidance across the regions and failure to prevent improper practices and claims in

[38]IDEA requires that, to the maximum extent possible, children with disabilities be educated with children without disabilities and that special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occur only when the nature or severity of the disability of a child is such that education in regular classes with the use of supplementary aides and services cannot be achieved satisfactorily. See 20 U.S.C. 1412(a)(5)(A).

some states. Without adequate controls and consistent oversight, Medicaid is vulnerable to paying for unneeded activities and services or for activities and services that have not been provided. Examples of such concerns follow.

- Bundled payment systems have the potential to reduce adverse incentives that are created by other payment systems, such as fee-for-service and cost-based reimbursement. Although additional safeguards can strengthen the benefits associated with bundled rates, we believe that prohibiting the use of bundled rates altogether, as HCFA recently did, is not warranted. Bundling rates can be an acceptable payment mechanism, provided that (1) rates account for children's different levels of need and (2) rates are developed in such a way as to provide assurances that they are not vulnerable to manipulation or resulting in inadequate services.
- With regard to administrative cost claims, poor controls have resulted in improper payments for Medicaid reimbursement in several states. As a result, Medicaid has reimbursed either for activities that were not covered or for children who were not eligible for Medicaid. Furthermore, claims submitted for administrative activities performed by skilled professionals have been reimbursed at a higher matching rate than available documentation could support.
- Specialized transportation, for which HCFA provided policy clarification in May 1999, continues to be overseen and approved haphazardly, resulting in potentially inequitable practices for children with different types of disabilities across different regions.

Finally, inadequate HCFA oversight has created an environment ripe for opportunism and vulnerable to fraud.

- Contingency fees paid to private firms by school districts have created the incentive to inappropriately maximize claims for Medicaid reimbursement. Improprieties in claims identified by our investigations and those of HCFA demonstrate how weaknesses in federal and state efforts to curtail this incentive can result in improper costs.
- When states stand to benefit financially by retaining a substantial share of schools' federal Medicaid reimbursements, the potential exists for a conflict of interest in ensuring that adequate oversight and controls are in place to ensure the appropriate use of Medicaid funds.

Recommendations to the Administrator of HCFA

In order to improve the development and application of policies for Medicaid reimbursement of claims for allowable school-based health services and administrative activities, we recommend that the Administrator of HCFA

- allow the use of bundled rates as one of several alternative payment approaches, provided that HCFA establishes consistent principles for bundling that effectively address (1) provisions for rates that reflect or recognize varying levels of services to accommodate children and (2) assurances that children receive appropriate and needed services;
- develop a methodology to approve and monitor state practices regarding allowable costs for administrative activities in schools that establishes consistent federal requirements for methods of allocating costs to Medicaid and accounting for professionals' time; and
- clarify the agency's policy on specialized transportation, with the goal of establishing policies that offer equitable treatment for children with different types of disabilities.

Agency and State Comments

We provided HCFA and the state Medicaid agencies we visited an opportunity to comment on a draft of this report. With respect to bundled rates for health services, HCFA commented that its May 1999 position emanated from its concern that the existing methodologies did not meet statutory requirements for payments consistent with efficiency, economy, and quality care. In considering future requests for bundled rate payments, HCFA indicated it would address such issues as reasonable payment levels, adequate documentation that covered services are provided only to Medicaid-eligible children, and sampling methodologies to verify the accuracy of documentation. This approach should provide better assurances that payment rates reflect children's varying needs and that services paid for were provided, but we would caution that new requirements not create a de facto fee-for-service environment and thus undermine the intended benefits associated with a bundled payment approach.

HCFA concurred with our recommendations on administrative cost claims and specialized transportation. With respect to administrative claiming, HCFA listed a number of steps it said it would take to address our recommendations. Among other things, this list included revising and finalizing a Medicaid school-based administrative claiming guide that it released for public comment in February 2000, providing training and

technical assistance to states and school districts to facilitate their efforts, and developing processes for monitoring existing school-based claiming activities and approving states' changes in this activity. HCFA expressed its commitment to working with its various partners—including the Department of Education, states, and schools—to better ensure the proper and efficient operation of Medicaid school-based programs. (See app. II for HCFA's comments.)

Most of the states that responded commented that our analysis of Medicaid reimbursement received by schools, as shown in table 7, did not reflect the portion of local school funding provided by the states. In addition, some states continue to assert that their retention of a share of federal Medicaid reimbursement is justified as reimbursement for their own level of funding support to schools. We continue to believe that it is not clear that state, rather than local, funds support the Medicaid-reimbursable services as opposed to other educational activities for which states provide funds. Moreover, we believe that such practices sever the direct link between Medicaid payment and services delivered, increase the potential for federal funds to be diverted to purposes other than those intended, and are inconsistent with the program's fundamental tenet that federal dollars are provided to match state or local dollars for Medicaid services delivered to eligible individuals. Finally, a few of the states said that additional guidance is needed for how states should claim federal reimbursement for administrative costs and specialized transportation.

HCFA and the state Medicaid agencies also provided technical comments, which we incorporated as appropriate.

We are providing copies of this report to the Honorable Donna E. Shalala, Secretary of Health and Human Services; the Honorable Nancy-Ann Min DeParle, Administrator of HCFA; appropriate congressional committees; and other interested parties.

If you or your staff have any questions about this report, please call Kathryn G. Allen at (202) 512-7118. For questions regarding our investigation, contact Robert H. Hast at (202) 512-7455. Other staff who made major contributions to this report are listed in appendix III.

Kathryn G. Allen
Associate Director, Health Financing and
Public Health Issues

Robert H. Hast
Acting Assistant Comptroller General
Office of Special Investigations

Health Care Financing Administration Letter Dated May 21, 1999

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

May 21, 1999

Dear State Medicaid Director:

This letter addresses reimbursement for school-based health services under Medicaid. School-based services play an important role in assuring that Medicaid-eligible adolescents and children receive needed health care. In particular, Medicaid is the payer of first resort for medical services provided to children with disabilities pursuant to the Individuals with Disabilities Education Act (IDEA). Although HCFA strongly supports the provision of school-based health services, it is important that these services meet applicable Federal Medicaid requirements. This letter clarifies HCFA policy in three areas: (1) use of a bundled rate to pay for medical services provided to Medicaid-eligible children in schools; (2) State claiming for school health-related transportation services for children with Individual Education Plans (IEPs) under the IDEA; and (3) State claiming for school health-related administrative activities.

Bundled Rates for School-Based Services

We and key Congressional Committees have identified a concern related to the "bundling" of school-based health services. We believe you share our interest in maintaining the fiscal integrity of the Medicaid program and, because of the risks discussed below, we are changing our policy in this regard.

A number of States have been paying for school-based services using a "bundled rate" methodology. This permits schools to minimize paperwork by billing for a package of medical services, rather than for each individual service provided to each child. A bundled payment rate exists when a State pays a single rate for one or more of a group of different services furnished to an eligible individual during a fixed period of time. The payment is the same regardless of the number of services furnished or the specific costs, or otherwise available rates, of those services. The bundle may include two or more components usually provided by different providers, each with their own unique provider qualifications, even if the components fall within the same 1905(a) service category. For example, bundling exists when two or more component services are provided under the rehabilitative services benefit even if all of the school-based services are identified in the State plan as being contained within that one 1905(a) service category.

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Our concerns are related to the fact that bundled rates for school-based providers are not related to a specific type of procedure and are generally not available to all qualified providers in the community who might wish to be similarly reimbursed. Furthermore, schools do not maintain the types of medical documentation that establish the reasonableness or accuracy of a rate. Because of these factors, HCFA has concluded that these bundled rate methodologies do not produce sufficient documentation of accurate and reasonable payments, and may result in higher payments than would be reasonable on a fee-for-service basis for each individual service and thus do not meet the statutory intent of the law. Section 1902(a)(30)(A) of the Social Security Act requires that States have methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care. We believe that a bundled rate for school-based services is inconsistent with economy, since the rate is not designed to accurately reflect true costs or reasonable fee-for-service rates, and with efficiency, since it requires substantially more Federal oversight resources to establish the accuracy and reasonableness of State expenditures. There is therefore no reliable basis for determining that the rate is related to the actual cost to the State and other public entities, absent documentation of the individual services provided.

Effective immediately, HCFA will no longer recognize bundled school-based health services rates as acceptable for purposes of claiming Federal financial participation (FFP). States that are currently paying bundled rates for school-based health services pursuant to an approved State plan amendment must develop and prospectively implement an alternative reimbursement methodology. We will be convening a meeting with a group from the States and the Department of Education to discuss options that are available. Also, States will be given time to work with the HCFA regional offices which will assist in the development and implementation of a non-bundled reimbursement methodology.

HCFA would like to work with states to implement a strategy so that States can come into compliance prospectively. At this time, no retroactive disallowances of FFP are planned nor are prospective deferrals. However, we expect states to work to come into compliance with this policy expeditiously. We recognize that some may require authorization or action by the State Legislature to implement a new reimbursement methodology. In the event that States do not come into compliance within a reasonable time, HCFA will consider taking a compliance action, including deferrals and retrospective disallowances to the date of this letter.

HCFA will not approve any additional amendments to State plans that seek to reimburse for school-based health services using a bundled rate. States with pending bundling plan amendments may either withdraw those amendments or revise them to conform to the requirements described in this letter. If the State wishes to retain the effective date of the amendment, HCFA will assist the State to develop an approvable amendment. An approvable amendment must include requirements for maintaining documentation of the individual services provided to support claims for FFP. It should be noted that the IEP is not sufficient for purposes of documenting services provided since it identifies only those services that a child should receive, and not those services that the child actually receives.

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Transportation

HCFA's policy concerning Medicaid payment for transporting Medicaid-eligible IDEA children to and from schools is described in the Medicaid and School Health Technical Assistance Guide. The Guide indicates that transportation to and from school may be claimed as a Medicaid service when the child receives a medical service in school on a particular day and when transportation is specifically listed in the IEP as a required service.

It is our understanding that an IEP should include only specialized services that a child would not otherwise receive in the course of attending school. Therefore, HCFA would like to clarify that a child with special education needs under IDEA who rides the regular school bus to school with the other non-disabled children in his/her neighborhood should not have transportation listed in his IEP and the cost of that bus ride should not be billed to Medicaid.

If a child requires transportation in a vehicle adapted to serve the needs of the disabled, including a specially adapted school bus, that transportation may be billed to Medicaid if the need for that specialized transportation is identified in the IEP. In addition, if a child resides in an area that does not have school bus transportation (such as those areas in close proximity to a school) but has a medical need for transportation that is noted in the IEP, that transportation may also be billed to Medicaid. As always, transportation from the school to a provider in the community also may be billed to Medicaid. These policies apply whether the State is claiming FFP for transportation under Medicaid as medical assistance or administration.

When a State claims FFP under the Medicaid program for transportation services as medical assistance under an approved reimbursement rate, the requirements for documentation of each service must be maintained for purposes of an audit trail. This usually takes the form of a trip log maintained by the provider of the specialized transportation service. The methodology used to establish the transportation rate should also be described in the State plan.

When FFP for the costs of transportation services is claimed as administration, the requirements of the Office of Management and Budget Circular A-87 for determining allowable costs, as well as any other applicable requirements for claiming administration under Medicaid, must be met. This includes the development of a cost allocation methodology to ensure that Medicaid only pays for that portion of the specialized mode of transportation allocable to Medicaid beneficiaries.

Effective July 1, 1999, FFP will only be available for Medicaid school-based transportation cost as administrative activities in accordance with the policies described above. Similarly, FFP for IEP related transportation services will only be available for services provided on or after July 1, 1999 as specified in this letter. HCFA's regional offices will provide technical assistance to States to assist them in properly claiming FFP for school-related transportation.

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Administrative Claiming for School-Based Services

HCFA is currently reviewing practices related to State claiming for school-based administrative activities. A guide is expected to be published this Summer which clarifies the requirements for claims for Medicaid expenditures for administrative activities performed in schools.

HCFA regional and central office staff will provide every assistance to States in their efforts to conform to these policies.

Sincerely,

/ s /

Sally K. Richardson
Director

cc:

All HCFA Regional Administrators
All HCFA Associate Regional Administrators
for Medicaid and State Operations
Lee Partridge - American Public Human Services Association
Joy Wilson - National Council of State Legislatures
Matt Salo - National Governors' Association

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & [illegible]

DATE: MAR 29 [illegible]

TO: Kathryn G. Allen, Associate Director
Health Financing and Public Health Issues

FROM: Michael M. Hash
Deputy Administrator
Health Care Financing Administration

SUBJECT: Draft Report "Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight" GAO/HEHS-00-69

We appreciate the General Accounting Office's (GAO) review of state practices regarding Medicaid reimbursement of school-based administrative activities and the use of "bundled" rates for school-based services.

The Health Care Financing Administration (HCFA) is committed to ensuring that Medicaid-eligible children are enrolled in Medicaid and receive the services they need. Schools offer unique advantages and opportunities to reach children and encourage their families to enroll in the Medicaid program, as well as to provide assistance to students in accessing medical services.

At the same time, however, we share your concerns about --and are taking action to prevent-- improper claims for federal Medicaid funds for the cost of such services. Clearly, there are challenges that must be overcome. We are committed to working with states and school districts to ensure that Medicaid dollars are only used on behalf of Medicaid-eligible children for Medicaid covered services. To help achieve this goal, we have developed a new and comprehensive guide for states to ensure proper identification and allocation of administrative costs associated with the provision of Medicaid services.

Overall, we share with the GAO's concerns and believe active efforts that we have underway will help ensure that children covered by Medicaid receive the necessary services they need to grow up healthy and that funds are spent correctly under the law.

Attachment

Comments of the Health Care Financing Administration on the General Accounting Office (GAO) Draft Report "Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight"

School-based health programs provide a broad range of services that are covered by Medicaid, affording access to care for children who otherwise might go without needed services. School-based programs can be effective and efficient providers of care, and can play a powerful role in identifying and enrolling children who are eligible for Medicaid. The Health Care Financing Administration (HCFA) is committed to ensuring that Medicaid-eligible children are enrolled in Medicaid and receive the services they need. We strongly support the provision of Medicaid covered services by schools.

We agree with the GAO that states have faced challenges in making proper claims for administrative costs related to providing school-based Medicaid services, using bundled rate methodologies, and billing for school-related transportation. We have acknowledged that confusion about the requirements for claiming Federal funds may have resulted in inappropriate claims. And, in the case where one state clearly had claimed improperly, we have taken action to defer claims.

We appreciate the GAO's acknowledgement of our efforts to improve the oversight of administrative claiming, and we agree that more needs to be done. We are committed to ensuring that states understand their opportunities and obligations regarding the use of Medicaid in schools.

To that end, we have been working with Congress, the Office of Management and Budget (OMB), and others to develop the *Medicaid School Based Administrative Claiming Guide* (the Guide). A draft of this guide is now being circulated to State Medicaid Agencies, schools and other interested parties for feedback. It is intended to help schools provide Medicaid services by consolidating existing requirements for claiming related administrative costs, and to provide a consistent national statement of these requirements. It does not establish new policies. Once we have reviewed public comments and issued a final guide, we will work aggressively to help all relevant parties understand how to use it.

The Guide and the training effort will only be part of our approach to resolving these issues. As discussed in detail below, we also are working to improve the collection and analysis of data on state Medicaid school-based program expenditures, and reviewing our

oversight and monitoring in this area overall. And, we will provide additional guidance and technical assistance on both the school-based transportation and bundling issues.

GAO Recommendation 1

Allow the use of bundled rates as one of several alternative payment approaches, provided that HCFA establishes consistent principles for bundling that effectively address: (1) provisions for rates that reflect or recognize varying levels of services to accommodate children and (2) assurances that children receive appropriate and needed services.

HCFA shares the GAO's concern that payment methodologies should appropriately balance the need to ensure the proper expenditure of Medicaid funds and the flexibility of states to expend funds without facing undue administrative burdens. That is why, in our May 1999 letter on this issue, we said that HCFA would not approve any more bundling methodologies. This suspension was to allow time for HCFA to review our policies so that improved methods of reimbursing for school-based services that meet the requirements of the law and our commitment to program integrity could be considered. We agree with the GAO report that bundling methodologies can place Medicaid at risk for improper claims.

Under a bundling system, states make weekly or monthly payments to schools based on a package of services that are needed by children with various categories of disabilities, rather than paying separately for individual services. Many different services may be included in the bundled rate, such as physical therapy and speech therapy. The payment is the same regardless of the number of services actually provided or the specific costs of the services involved.

As noted by the GAO report, there is concern that school-based providers may not maintain adequate or readily available documentation for bundled payments, may not have the administrative infrastructure needed to do so, or may not have used such documentation in developing bundled payment methodologies. Without proper documentation, there is no reliable basis for determining whether the needed service was delivered at a reasonable rate. This creates the opportunity for states to obtain Federal matching funds for services that have not been provided. It also allows for the possibility that states could claim funds for services that are not covered by Medicaid.

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Therefore, we have determined that existing bundled rate methodologies do not meet the statutory intent of the law. Section 1902(a)(30)(A) of the Social Security Act requires that states have methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care. The process used for bundling was inconsistent with economy, since the rates were not designed to accurately reflect true costs or reasonable fee-for-service rates. The process was not consistent with the efficiency requirement, since it required substantial Federal oversight to establish the accuracy and reasonableness of state expenditures. As a result, there was no reliable basis for determining that the rate was related to the actual cost.

Underlying the May 1999 letter is a simple, but critical, principle for bundled payment methodologies -- Medicaid funds must only be used to provide Medicaid covered services to Medicaid-eligible children. The law is clear on this. There are a few additions to this principle (such as outreach and enrollment assistance, but they are the exceptions that prove the rule.) However, identifying a means of implementing this principle while balancing the need for appropriate program integrity measures without undue administrative burden has been difficult.

That is why, since our May 1999 letter, we have worked continuously to identify alternative approaches that will fulfill the law's requirements. We created a workgroup with representatives of State Medicaid Agencies, the Department of Education, local education agencies and OMB. The workgroup was designed to make sure that HCFA staff could hear a variety of perspectives on this topic, but it was not intended to be a decision making body, as implied by the GAO report. Through this activity, we identified several issues that should be considered in bundled payment methodologies for school based services. These issues -- in some ways implicit in the ones identified by the GAO -- are:

- **Provision of adequate documentation that** goes beyond requiring simple "assurances." States need to provide detailed information at the provider or school level to establish an audit trail and develop methods for the maintenance of documentation.
- **Utilization of retrospective reconciliation of services and costs or other safeguards.** There must be safeguards to assure that the bundled payment methodology continues to reflect the services that are delivered to Medicaid-enrolled children.
- **Creation of reasonable payment levels.** States need to identify the specific services and their reasonable costs for inclusion in bundled payment. The rates must recognize varying levels of services needed by children with different health care needs.

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- **Development of sampling methodologies to** accurately identify services provided to Medicaid-eligible children with disabilities who have an Individualized Education Plan (IEP). The sampling methodology should take into account the medical needs of children with varying disabilities and geographic distribution of children with disabilities.

Any methodology that does not address these issues could place the Federal government at risk for expenditures not permitted by law.

GAO Recommendation 2

Develop a methodology to approve and monitor state practices regarding allowable costs for administrative activities in schools that establishes consistent Federal requirements for methods of allocating costs to Medicaid and accounting for professionals' time

HCFA concurs. As stated earlier, HCFA is committed to supporting the use of schools as centers for providing Medicaid outreach, assistance in the eligibility process and services as allowed by law and as necessary to fit each State's particular needs. While state flexibility is important, states also have the obligation to exercise their flexibility in the constraints of the law. HCFA encourages state flexibility but is required to ensure the integrity of the Medicaid program and to ensure that proper financial controls are consistently applied. Therefore, we are already taking a number of steps that respond to the above recommendation, including:

- **Developing the Medicaid School-Based Administrative Claiming Guide.** We agree that there must be a uniform national statement of requirements for claiming the costs of school-based administrative activities. The Guide should address many of the concerns raised by the GAO. It is intended to summarize and clarify all existing Federal laws, regulations and policies. It will serve as a reference on all aspects of school-based administrative claiming. For example, it includes a thorough discussion of claiming for administrative activities performed by skilled professional medical personnel, one of the areas highlighted in the GAO report. We released a draft of the guide in February 2000 and extended the deadline for public comments until April 3rd. And we are committed to working with the states, schools, and the Federal Department of Education to appropriately revise and clarify it before issuing in final. The Guide is currently available on the HCFA web site at www.hcfa.gov.

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- **Providing Training and Technical Assistance to States.** Once the guide is released, we will follow an aggressive schedule of training for interested parties. This will include regional conference calls as well as a national training session in Baltimore within 60 days of the Guide's final release.
- **Providing Training and Technical Assistance to School Districts.** School districts will be a critical part of our training effort. In fact, we have already begun working with school districts to foster an understanding of related policy. We will take steps to ensure that materials and technical assistance are part of our training effort.
- **Developing a Process for Monitoring Existing Claiming Activities.** We will review existing Medicaid expenditure reporting and work with states to identify additional data that should be gathered. This effort will also include gathering information regarding specific State activities on school-based claiming both from the States and from documents within the Department of Health and Human Services (HHS).
- **Developing a Process for Approving Changes in School-Based Administrative Claiming Activities.** States are already required to submit public assistance cost allocation plans to the Division of Cost Allocation (DCA) at HHS. These plans must reference the Medicaid school-based administrative claiming programs which must be reviewed prior to any final approval prior of the cost allocation plan. We are taking concrete steps to strengthen this process so that any future changes in claiming procedures by states will be part of the formal review and approval process.
- **Providing Clear Feedback to States to Ensure Compliance.** We will work with states as partners to ensure that, prospectively, proper claiming methodologies are used. When required by law, HCFA will recoup inappropriately claimed funds.
- **Developing Financial Management Strategy/Review Guides.** We will review existing procedures, review guides, and manuals on the oversight of school-based services and administrative activities and incorporate the Medicaid School-Based Administrative Claiming Guide into formal financial management tools.
- **Increased Oversight of Conflicts of Interest.** We will strengthen our review of state claims to ensure that contingency fees are not claimed. We share the concerns expressed by the GAO that private firms who receive a percentage of reimbursement as payment for consulting and billing services, rather than a fixed fee, have an incentive to maximize the amount of reimbursement claimed. In addition, while we also share GAO's concerns about states retaining a share of Federal funds related to schools' claims, this practice is allowable under current law.

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These activities will help to address concerns raised by the GAO, including time study sampling methodologies and the use of activity codes. The time study is the primary mechanism for identifying and categorizing activities performed by school or school district employees, and for developing claims for the costs of these administrative activities that may be properly reimbursed under Medicaid. The draft Guide provides standard activity codes that may be further tailored to reflect local differences. Such an approach addresses the GAO's concern for a balance between state/local flexibility and consistency within and across states.

We recognize that many difficult issues and challenges remain to ensure state compliance with the law. We are committed to taking all necessary steps to ensure the proper and efficient operation of Medicaid school-based programs, and will be working with our Federal, state, and local partners to continue to identify and address these issues.

GAO Recommendation 3

Clarify the agency's policy on specialized transportation with the goal of establishing policies that offer equitable treatment for children with different types of disabilities.

We concur. The May 1999 letter did provide useful guidance to states on several issues:

- Transportation to and from school may be claimed as a Medicaid service when the child receives a medical service in school on a particular day and when transportation is specifically listed in a student's Individual Education Plan as a required service.
- If a child requires transportation in a specially adapted vehicle, including a specially adapted school bus, that transportation may be billed to Medicaid.
- Transportation from school to a provider in the community may be billed to Medicaid.
- States must provide documentation of transportation service, usually in the form of a trip log maintained by the provider of the specialized transportation service.
- States must describe the methodology used to establish the transportation rate in the State Medicaid plan.
- States must develop a cost allocation methodology to ensure that Medicaid only pays for that portion of the specialized transportation attributable to Medicaid beneficiaries.

We agree with the GAO that the policy described in the May 1999 letter resulted in some confusion on the part of HCFA regional offices and states. We will issue additional guidance, especially as it relates to transportation issues. We plan to further clarify the specific types of specialized transportation that may be claimed for children with an IEP. We will work to assure that there is a uniform application of this policy.

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